

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:

G. PETER FOOX, MD
1405 S. FLEISHEL AVE #330
TYLER TX 75701

MFDR Tracking #:

M4-09-A304-01

Respondent Name and Box #:

TEXAS MUTUAL INSURANCE CO
REP BOX #54**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary: "Request payment per TX Fee Guide for ts (sic)... The patient was sent for IRI review... she was at MMI. ROM and IR was calculated... the fee is 350 + 300 = 650."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - \$300.00
3. CMS 1500s
4. EOB(s)
5. DDE Narrative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Texas Mutual believes the examination performed by G. Peter Fook, M.D., (doctor selected by treating doctor) to determine MMI/IR is not due payment for the IR portion because the injury was sufficiently minor. The principal treatment was an ace bandage, leg boot and NSAIDS for the injury sustained on 1/19/2009 (lower leg pain). Texas Mutual believes, based on the length and type of treatment provided, the injury was sufficiently minor and does not warrant an impairment rating. Consistent with Rule 134.204(j)(1)(2)(B) the requestor is entitled to payment for the MMI evaluation portion of the examination, which Texas Mutual paid."

Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
04/16/2009	99456-WP	1-9	\$300.00

Total:

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and 28 Texas Administrative Code (TAC) Section 134.204, titled *Medical Fee Guideline* effective for specific services on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason codes:
 - CAC-W1: WORKER'S COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
 - 790: THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
 - CAC-W4: NO ADDITIONAL REIMBURSEMENT ALLOWED AFTER REVIEW OF APPEAL/RECONSIDERATION.
 - CAC-18: DUPLICATE/CLAIM/SERVICE.
 - 891: THE INSURANCE COMPANY IS REDUCING OR DENYING PAYMENT AFTER RECONSIDERATION
 - 878: DUPLICATE APPEAL. REQUEST MEDICAL DISPUTE RESOLUTION THROUGH DWC FOR CONTINUED DISAGREEMENT OR ORIGINAL APPEAL DECISION.
2. The Table of Disputed Services reflects a payment of \$350.00 of \$650.00 billed for CPT 99456-WP and a disputed amount of \$300.00.
3. Rule 134.204(j)(4)(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis; 19
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area..
4. The CPT code 99456-WP is billed by Requestor and documented in the narrative as a Maximum Medical Improvement (MMI) determination and Impairment Rating evaluation (IR) for knee and ankle (lower extremity) range of motion ROM. Measurements taken with a goniometer technique were utilized to determine zero (0%) IR.
5. The Respondent initially denied/reduced reimbursement per CAC-W1 only. Subsequent EOB(s) indicated that no additional reimbursement was due or deemed duplicate billing.
6. In a Respondent correspondence received after MFDR, a new issue was brought up in Rule 134.204(j)(1)(2)(B) which cited:

If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.
7. The Respondent indicates that the injury was so "significantly minor", given the treatment history, that even consideration of an Impairment Rating evaluation was not warranted according to Rule 134.204(j)(1)(2)(B).
8. The Requestor does not mention a "significantly minor" injury but rather a "significant sprain to the right calf

muscle.” The history of the patient shows that there was treatment for roughly 3 months at which time the treating doctor referred to Dr. Foox for evaluation. The examining physician, Dr. Foox rendered an independent examination for a valid assessment of both the injured worker’s MMI and IR status. A “zero percent” IR rather than a “no impairment” rating was Box 18b on the DWC-69.

9. Therefore, additional reimbursement of \$300.00 recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1
Texas Government Code, Chapter 2001, Subchapter G
134.204

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to an additional **\$300.00** reimbursement for the services involved in this dispute.

ORDER:

Authorized Signature

Auditor
Medical Fee Dispute Resolution

October 30, 2009

Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.